Attachment
Formal California IHSS Plus Demonstration
Request for Additional Information (RAI)
May 27, 2004

Eligibility

1. It is CMS' understanding that the IHSS Plus eligible population will be determined Medi-Cal eligible under State plan procedures. Please prepare a plan and timeline by which determinations will be made.

2. FFP will not be available for unqualified aliens or those subject to the 5-year bar. However, the state may continue to cover these individuals through State-only funds or may discontinue their participation from the IHSS.

3. SSI procedures for determination of presumptive disability will need to be followed. Please describe the State's process for presumptive disability, including usual timeframes in which a disability determination is made.

    a. Is there a significant difference in the number of those found eligible for presumptive eligibility/services and those found later to not qualify when the final disability determination is made?
    b. If a person is found not disabled, how and when is the eligibility stopped?
    c. Are there any circumstances under which the person could remain eligible for services, i.e., in the residual program?

4. The State's proposal indicates that persons who were once eligible for SSI but who are now ineligible because of engaging in SGA (substantial gainful activity) are currently eligible for the residual program. Are these same individuals eligible for Medi-Cal—are they 1619(a) or (b), Ticket or Buy-in?

5. The State's proposal has requested an effective date of January 1, 2004. The proposal states that eligibility for Medi-Cal is determined by county Medi-Cal eligibility workers who make eligibility decisions using current Medi-Cal eligibility rules. However, the draft All County Welfare Director's Letter (Appendix 7) refers to ABD-MN cases, A& D FPL cases, and 250% WD cases, and states "Counties must ensure that these Medi-Cal eligibility determinations are being made by Medi-Cal eligibility workers effective July 1, 2004."

    a. Who is making the eligibility determination for residual cases prior to July 1?
    b. When was the process changed, or has it been changed, from the prior practice which employed non-Medi-Cal workers to make these eligibility determinations?

6. DSS MPP-30-701 (d) 1 references "deeming of certain relatives living in the household". Please describe who is included in the term "certain relatives".

7. Please define the terms (i.e., headings in columns and rows) used in the Eligibility Matrix furnished by the State.

8. How does the table on page 6 of the proposal, depicting IHSS RP users and target populations, jibe with the Elgibility Matrix the State furnished subsequently? Please explain the differences in the numbers in these documents.

9. DSS MPP 30-755 1.12 references those "currently institutionalized". Please clarify whether “currently institutionalized” includes persons institutionalized in an IMD.

10. How are the IHSS participants similar or different from the Medi-Cal PCSP? For example, are they less or more disabled, based on ADL/IADL needs? What percentage of IHSS RP participants meets the functional eligibility requirements for the State Plan PCSP? Do all the people in the IHSS RP qualify for the State Plan PCSP?

11. Would individuals who currently receive personal care services under the State Plan PCSP have the option to enroll in the IHSS Plus Demonstration program? And, vice versa, could individuals enrolled in the IHSS Plus Demonstration program elect to receive personal care services via the State Plan PCSP? Please explain.

Spend-down and Share of Cost Determinations

12. We expect standard Medicaid cost determinations (e.g., spend-down and share of cost) (SOC) to be made. We understand that the IHSS populations are Medically Needy populations, however, Appendix 7 deviates from federal Medicaid rules for determining spend-down. If the State is envisioning a waiver of Medicaid rules to accomplish what is set forth in Appendix 7, then there will need to be further discussions and a new budget model developed for the demonstration. Please compare and contrast what is currently being done under Medi-Cal to what is proposed in Appendix 7, and include in your response, answers to the following:

    a. The draft letter in Appendix 7 provides instructions for expanding personal care services to the ABD-MN, the A&D FPL group, and the 250% Working Disabled group. Do these instructions apply to other medically needy groups?
    b. Are personal care services available to non-ABD medically needy recipients?
    c. The State proposes a payment “buy-out” to CMS from the state general fund when a converted ABD-MN PCS recipient’s SOC is greater than his IHSS SOC. The recipient pays the lower SOC. However, buy-out is not allowed under the Medicaid program. It should also be noted that payment of the spend down is not a condition of Medi-Cal eligibility. Please reconcile the practice with Medicaid and Medi-Cal requirements.
    d. The proposal states that payment of the entire obligated SOC is a condition of eligibility for IHSS. How is IHSS eligibility handled when the individual meets his SOC by incurring other medical expenses? Please share the rationale for having different SOC methodologies for these (IHSS/PCSP and/or residual) individuals. Does it vary by program or service? The proposal goes on to state that IHSS will be terminated if the recipient fails to pay the entire obligated SOC

within the month it is obligated. This is not consistent with Medicaid spend down policy. Per 42 CFR 435.831(d), medical expenses need only to be incurred, not fully paid, to be considered in meeting SOC. Section 30-768.24 states that if a recipient does not pay his obligated SOC, the county should initiate recovery for the entire amount of the IHSS payment for the month the person was ineligible. Please reconcile the practice with Medicaid and Medi-Cal requirements.

e. Please explain if failure to pay the entire obligated SOC within the month takes into consideration special life circumstances when a payment is missed.
f. Please explain assessed needs in relationship to example 2 on page 46. Please clarify the last paragraph of the example that explains the treatment of assessed needs. Could a MN individual qualify for personal care under the state plan personal care option?

13. The draft refers to "Sneede" and "Gamma"case decisions. Since these cases deal with impermissible deeming, does the waiver cover AFDC-related medically-needy individuals? In the explanation of the "target population" the State mentions only ABD medically-needy. Please clarify.

Compliance, Claiming and Reimbursement

14. Much of what is in Appendix 5 and Appendix 6 appears to be out of date. What are the current standards used in the IHSS program?

15. It is expected that State Plan polices and procedures will govern. Please prepare a plan and timeline by which all IHSS/PCSP policies and procedures that differ from State Plan Medicaid policies will be updated, including spend-down and share of cost policies and procedures, recovery of overpayments for non-PCSP payments, exemption of motor vehicle provisions and disposal of assets provisions (inclusion of liquid assets unclear.)

16. There is a concern about the potential for duplication of services and duplication of payments, resulting in overpayments and erroneous claiming of FFP. How will the State monitor, particularly given the existing systems limitations and the lack of system(s) interface that currently exist? (e.g., the current inability to interface with MMIS or Medi-Cal Eligibility Data Systems (MEDS); Caseload Management Information and Payroll System (CMIPS II) Draft Proposal showing implementation of needed systems changes 2008-2009.) Please provide a plan describing how the State will properly track, pay and report claims.

17. Section 30-700.3 states: "Individuals who qualify for both IHSS and PCSP funding shall be funded by PCSP." Please explain what this means.

18. Is it anticipated that persons will be able to participate in more than one waiver—for example, the proposed IHSS+ and HCBS waivers, or IHSS+ and Personal Care State Plan services? If so, please describe how participation in more than one program

works, providing examples of combinations such as Residual and Personal Care State Plan (PCSP) participation, Residual and HCBS waiver participation, Personal Care State Plan services and HCBS participation.

Budget Neutrality

19. Please provide answers to the following based on the budget data furnished May 10, 2004:

    a. Were non-Medicaid eligible individuals' costs included in the historical data, the member months and in the projections?
    b. Were non-Medicaid eligible individuals' member months included in the historical data?
    c. According to the methodology description, impacted state plan services include personal care services, DME, and home health agency services. What number or percentage of the current IHSS recipients receives these services? The 5/10/04 data from the State include separate amounts for impacted and IHSS RP self-directed expenditures. Have there been adjustments to the data since 5/10/04?
    d. What is the average cost of personal care services for persons in the State Plan PCSP, excluding those who receive services under the IHSS RP. What is the growth rate for these services using the same timeframe used in the proposal (1999 to 2001)?
    e. Growth in expenditures from 1999-00 through 2002-03 seems mostly to be due to cost per person increases (MM trend is low). This is an unusual cost trend for a personal care program. It seems to affect both Impacted and RP services. 17% is high rate to show for 199-00 through 2009 – ten years. What is the cause – severity changes? Assessment changes? Hourly reimbursement changes – minimum wage changes? More premium wages (payments over minimum occurring?)
    f. Please explain the expenditure and participation experience data for each component of the IHSS RP (Legally responsible family members, advanced pay, meal allowance, domestic services, protective supervision and multiple components)? Would the PMPM cost be adversely affected if some of these components are not available for FFP under section 1115 authority? Will the State be willing to walk us through the costs for services under each component?

20. Worker's Compensation costs are paid directly to the State Compensation insurance fund and have not been included in provider rates. The proposal states that the provider rate only covers wages and benefits, employer taxes, and administration. How are insurance costs to be incurred and claimed?

21. Please discuss all budget changes to the IHSS program, or that impact the IHSS program, proposed for 2004-2005 SFY, noting in particular whether the Governor's proposal to limit IHSS provider rates to minimum wage is still pending, and if so,

how will it impact the waiver submission with respect to budget neutrality information and workforce shortage.

22. If the State of California cuts provider wages to minimum wage, will local or county governments cover the portion of provider wages not paid by the State?

Public Notice Requirements

23. Did the State post a notice of the intent to submit a demonstration proposal in newspapers of general circulation, giving individuals a mechanism for how they could receive a copy of the proposal and comment on the proposal? If so, please provide a copy of the notice.

24. Did the State submit a notice to tribal organizations informing them of the proposed demonstration and requesting their comments? If so, please provide a copy of the notice.

Program Coordination

25. Please define the term "disability" as used in the DSS MPP 30-755.23.231. Is this applied uniformly in all counties.
26. Please clarify the criteria for discontinuing services by the transferring county as this could otherwise result in unnecessary terminations by the county of origin. DSS MPP 30-759.95.

Quality Management System

27. The State's proposal notes that it will implement many activities in the development of a Quality Management System that incorporates the features of the Quality Framework. Please provide a plan and timeline for phasing in needed monitoring and reporting mechanisms so the State will be able to fully comply with the requirements of discovery, remediation and improvement. Please address the following activities, not intended to be exhaustive, in the plan:
    a. Some counties have no “emergency back up system.”
    b. Regarding the “incident management system": What about situations that are not within the purview of Adult Protective Services or other agencies? Are such incidents tracked? How?
    c. How will DHS gather participant data and incident reports (discovery) from the counties? Discovery includes collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
    d. How will DHS oversee the remediation of identified problems? Remediation includes taking action to remedy specific problems or concerns that arise.

e. How will DHS implement continuous quality improvement? Continuous improvement includes utilizing data and quality information to engage in actions that lead to continuous improvement.
f. How will the State monitor that problems identified through the incident management system and the unusual event system are addressed and resolved in a timely and appropriate manner to protect participants?
g. Who pays for the criminal background check? Is it required in some situations or solely at the discretion of the recipient?
h. The third paragraph on page 18 states that training and support procedures will be made available to participants and caregivers through the activities of the State's IHSS Enhancement Initiative Real Choice Grant 91549\9. What products from the grant activities will be made available to waiver participants and providers? What are the critical milestones, timelines and the current status for the development and implementation of these tools?
i. The chart describing DSS quality assurance activities (Page 16, row 2 of chart at bottom of page) indicates that onsite (county) review activities will include sampling of recipient outcomes and satisfaction. What procedures and tools will be used to effectively carry out this activity?
j. The monitoring procedure entitled "Quality Improvement" (Page 17, last row) should specify who is responsible for carrying out QI activities, procedures to be employed including the frequency and methodology of QI activities, and products to be achieved as a result of these processes.
k. A procedure for on-site monitoring. Would the State evaluate and consider use of a call-in monitoring program by the care provider, such as that used by South Carolina?
l. What activities are contingent on the approval of the proposal for a new Caseload Management Information and Payroll System (CMIPS II) and development of improved MMIS?
m. What additional DHS resources will be required and requested?

Self-Directed Services/Benefits and Service Delivery Options

28. The proposal sets forth the roles and responsibilities of the Public Authorities. What are the roles and responsibilities of the Nonprofit Consortia, Joint Powers Agencies and County IPs?

29. Do participants have the option of being the Employer of Record? If so, under what modes of service delivery? For those participants who wish to be the Employer of Record, please describe all information and assistance given to them to fulfill their fiscal and employment-related functions.

30. *Please clarify to whom and how transportation is provided under the IHSS RP. DSS MPP 30-757.154.

31. Please clarify whether "Teaching and Demonstration Services" referenced in DSS MPP 30-757.181 can include family members or neighbors as “persons who ordinarily provide IHSS”.

32. Can the persons to be served in the IHSS Plus program be working? Please explain.

33. Please clarify whether respite care is provided, or will be provided under the demonstration program, in any "out of home care facility" referenced in DSS MPP 30-701 (o) 1.

34. Please clarify where personal care services can be provided. 34. Are criminal background checks available to all individuals in the IHSS RP? If not currently available, please prepare a plan and timeline for when they will be available.

35. County and Public Agencies track and handle provider no-show and recipient at risk – please describe all activities related to the response to provider no-show and recipient at risk other than 911? Would the State consider adding 24/7 contract or employed assistance for critical events that would otherwise place a client in jeopardy –case mangers on call 24/7 and/or individual and program back up plans?

36. Is an assessment completed for each participant of what may place each participant at risk of harm, including the failure of the participant's care provider to show up? Is there a contingency plan developed that would manage or resolve the risk? If not currently available, please prepare a plan and timeline for when individual risk assessment and contingency planning would be available.

37. Is there a system-wide contingency plan in the event the participant's contingency plan fails and the participant is placed at risk of harm? If not currently available, please prepare a plan and timeline for when a system-wide contingency plan would be available.

38. Please describe the qualifications of the social workers. Please describe the roles and responsibilities of the social workers. ,Please include in your answer whether the social workers have any of the following responsibilities:
    a. monitoring quality of care
    b assisting participants with learning their employer and/or fiscal related responsibilities
    c. accessing other needed supports in the community (outside of the IHSS Plus program)
    d. acting as a point of contact if participants have questions or their care providers are unavailable.

39. Please describe how participants who do not make a complaint to the Department of Mental Health or the Department of Developmental Services Office of Clients Rights Advocacy are able to access an independent advocate/advocacy service?

40. How are participants in IHSS assisted in providing the needed "training" to their personal care assistants?

41. Substitute Payee-DSS MPP 30-701 (s) (9): Please clarify whether “substitute payee” includes the fiscal intermediary. If not, please explain whom it may include.

42. Please define "full-time employment" as referenced in DSS MPP 30-763.45.451(a): (“When the recipient is under eighteen years of age and is living with the recipient's parent(s)”…and parent left "full time employment".)

43. Please explain who is a qualified provider when a recipient is under 18, as referenced in DSS MPP 30-763.45.452. ("a suitable provider" is any person who is "willing, available, and qualified".)

44. Please provide examples of alternative resources that may be used as referenced in DSS MPP 30-763.61. Please explain how possible errors in use of inappropriate care are avoided.

45. Please explain why compensation is a county-based rate and not one identified by the recipient. DSS MPP 30-764.2.

46. Please explain how each county's availability of personal care attendants is factored into the determination of a payment rate to a parent or spouse as a personal care attendant. DSS MPP 30-766.

Evaluation

47. There are no anticipated savings, and no new services, nor is the State expanding eligibility. What is the evaluative component of this demonstration project?

Funding Questions

48. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking the State to confirm to CMS that providers in the IHSS Plus §1115 Demonstration program would retain 100 percent of the payments. Would the State, through the IHSS Plus §1115 Demonstration program, participate in activities such as intergovernmental transfers or certified public expenditure payments, including the Federal and State share; or, would any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the IHSS Plus §1115 Demonstration program providers would be required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the

payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

49. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state's share of the Medicaid payment for the IHSS Plus §1115 Demonstration program would be funded. Please describe whether the state's share would be from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid payment. If any of the state share would be provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

50. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments would be made, please provide the total amount for each type of supplemental or enhanced payment made to IHSS Plus §1115 Demonstration program.

51. *This is applicable to inpatient hospital, outpatient hospital and clinic services.* Please provide a detailed description of the methodology *to be* used by the state under the demonstration program to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

52. Would any public provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?